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Health Policy 60 (2002) 111–132

HEALTH policy

www.elsevier.com/locate/healthpol

Primary care physicians' attitudes to health care reform in England

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Received 2 June 2001; accepted 25 August 2001

Abstract

Primary care organisation in England has been subject to particularly extensive and far-reaching reform in recent years. In 1991, a quasi-market was introduced into the National Health Service and general practitioners were offered the opportunity to manage independent budgets from which to purchase and deliver care services. Practitioners joined the scheme in increasing numbers, although it was eventually abandoned following a change of government in 1997. This paper reports the results of two surveys of primary care physicians' opinions on the English health care reforms, conducted in 1997 and 2000. It concludes that, first, those opting for discretionary budgets were significantly more supportive of the policy than those not joining the scheme and this support continued long after the scheme had been abolished. Second, professional attitudes, with respect to other terms of service in primary care, remained homogenous to a considerable degree over time. Finally, physicians in favour of imposing user charges tend to be those with responsibility for more patients, suggesting a perceived need to manage patient demand. © 2002 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Attitudes of health personnel; Fundholding; General practice; Health care reform; Primary care

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PII: S0168-8510(01)00188-9

1. Introduction

During the past two decades there has been, in the words of one commentator, a 'competition vogue' within the health care systems of industrialised economies [1]. The movement began with the development of managed care in the US, whereby pre-paid groups of care providers (such as Health Maintenance Organisations) competed for subscribers on the basis of offering the best possible care services at the lowest possible insurance premia. Within the public health care systems of Europe, the movement was translated into the implementation of market-like, contractual relationships between health care consumers or their agents, service suppliers and the agencies responsible for health care finance, such as governments or independent insurance funds. Irrespective of the precise form of organisation at the national level, the objectives in all cases have been the same—to drive up efficiency, to improve consumer choice and to control the escalating costs of health care [2].

In the main, the various policy reforms were engineered by the financiers of health care. These agencies operated within legislative frameworks supplied by governments and acted independently of the health professionals who would be charged with the delivery of care within the reformed structures. Whilst the purely technical aspects of reform, such as consequences for behaviour, have been reasonably well-researched in many countries, relatively little attention has been paid to professionals' opinions on, and attitudes towards, the reforms which were being, by and large, simply imposed upon them.

Primary care organisation in England has been subject to particularly extensive and far-reaching reform in recent years. Primary care physicians were offered a new and fundamental managerial role as a result of a major policy initiative in 1990, which introduced market-like structures into England's National Health Service (NHS). This role, however, became re-defined as a result of a change of policy (and of government) in 1997. In this paper, we report the results of two surveys conducted amongst primary care physicians, designed to elicit professional opinions on government health policy. The first was conducted immediately after the 1997 election, with the intention of eliciting attitudes towards the organisational changes which had been debated or had actually taken place since 1990. The second survey was conducted 3 years later, enabling us to investigate the extent to which the earlier opinions had changed or persisted, following the subsequent re-direction of policy.

Prior to presenting our methods and results, we review the key policy debates and initiatives which occurred during the 1990s. These ideas and events naturally defined the issues on which we were seeking opinions in our surveys.

2. The NHS and primary care

The NHS in England is, and always has been, financed principally from the general taxation revenues of central government. Modest charges are imposed in a

limited number of areas, such as prescribed medicines and dental care, although the vast majority of health services are provided to the public at zero price. In consequence, total health care spending is circumscribed by the government's chosen funding allocation to the NHS, considered in relation to its other public expenditure priorities. Perhaps not surprisingly, the NHS has long been characterised by persistent excess demand, which is generally resolved by requiring patients to wait for treatment.

The NHS maintains a clear demarcation between primary and secondary care. Every citizen is entitled to register with a primary care physician (a 'general practitioner' or GP), who thereby assumes a responsibility for that person's medical needs. The registered GP is the patient's first port of call when such a need arises. In the majority of cases, the GP will effect the treatment him/herself, for example, by prescribing medication. In more serious cases, however, the GP will arrange a referral to a secondary care specialist, in a hospital or clinic setting. Direct patient access to secondary care is uncommon in the NHS and is generally confined to accidents and emergencies. The GP is thus both patient advocate and 'gatekeeper' of the health service and his/her initial management decisions exert a major impact on overall health care resource use.

When the NHS was established in 1948, it was expected that all health care professionals would become salaried public employees. In contrast to their secondary care colleagues, however, the GPs resisted incorporation and have since maintained their status as 'independent contractors'. Acting either as individuals or as members of partnerships, GPs offer their medical services in return for remuneration based on a complex mixture of fees, allowances and expenses [3,4]. All GPs receive a flat-rate basic allowance, simply for being willing to accept NHS patients. Thereafter, remuneration depends on GP, patient and activity characteristics. For example, more experienced GPs may claim a seniority allowance, whilst those operating in economically-disadvantaged areas may claim deprivation payments. For each registered patient, the GP receives a capitation or responsibility payment, with older patients, who typically place higher demands on the GP's time, attracting higher payments. Certain specified activities attract fees-for-service, for example, vaccinations, maternity care and out-of-hours attendance. It follows that GPs with longer 'lists' of registered patients face the prospect of higher incomes, although at the expected cost of higher workloads. The average list-size and size of partnership in England and Wales are $\approx 2{,}000$ patients per GP and three to four GPs, respectively, although these averages conceal very wide variations. Some GPs still operate 'single-handedly', whilst partnerships of six or more GPs are becoming increasingly common. In any one area of the country, list-sizes can easily vary from between < 1000 patients per GP to > 3000.

Prior to 1990, the NHS was administered locally by some 200 District Health Authorities (DHAs), who retained responsibility for the provision of all NHS services beyond primary care. Primary care itself was managed by around half that number of Family Health Services Authorities (FHSAs). Both received their funds independently from the central government's Department of Health. In 1990, however, a major re-organisation was implemented, following proposals outlined in

a government White Paper [5]. Given the NHS's previous incarnation as a highly-centralised bureaucracy, these proposals had been exceptionally radical. They were, first, the classification of, on the one hand, health care purchasers and on the other hand, health care providers. The former were to be allocated NHS funds directly, to enable them to purchase care on behalf of patients for whom they were responsible. The latter were to compete between themselves to obtain the purchasers' revenue and to provide the care. As the process involved nominal sales and purchases within the NHS, the new organisational structure came to be labelled the 'internal market'. Second, financial and management decision-making was to be devolved away from the Department of Health towards the purchasers and providers. This surrender of central control was a logical requirement for the internal market to function and, if an activity required regulation, it would be accomplished by offering incentives. Finally, primary care was to become the main driver of the entire NHS structure, a role entirely consistent with the advocate/gatekeeper function of the GP.

As a result of the 1990 National Health Services Act, each DHA became a purchaser, abandoning its former responsibilities for operating local hospitals and community services in favour of both assessing local population health needs and commissioning care services to meet those needs. The services were to come from soon-to-be-independent providers of care—hospitals and community health services granted financial and managerial autonomy—and would be financed by a centrally-allocated, needs-related, purchasing budget. Larger general practices were invited to apply to hold budgets or 'funds' in their own right, thereby replacing the DHAs as purchasers for those patients specifically registered with them. New words entered the vocabulary—the independent providers became 'trusts' and GPs with their own budgets became 'fundholders'.

Naturally, all these changes did not take place overnight. Not only would this have proved logistically impossible to organise, but the government feared that over-rapid change would destabilise the entire system. Moreover, the medical profession generally was initially hostile to the internal market and fiercely so [6]. Trusts and fundholders were therefore recruited gradually, in a series of annual waves, following a process of assessment of suitability for independence. Over time, the regulations for fundholding eligibility were eased, to encourage smaller practices to enter the scheme. Initially, the range of services that each fundholder could purchase on behalf of patients was restricted to prescribed medication and a range of both diagnostic tests and relatively commonplace clinical treatments. Eventually, however, it became possible for fundholders to assume purchasing responsibility for virtually all aspects of care, if they so wished [7].

Organisational transition was not instant, but it was certainly rapid. The first of the trusts and the fundholders began operating in 1991. Within 5 years, virtually all of the hospitals and community health services had achieved trust status and more than half of the population of England and Wales was registered with fundholding GPs. With centralised direction of activity in decline, the independent roles of the DHAs and FHSAs were becoming increasingly anachronistic. Accordingly, they were replaced by ≈ 100 unified Health Authorities (HAs), responsible for the

declining amount of health care commissioning outside the hands of fundholders. This included the continuing responsibility for purchasing care on behalf of the declining number of non-fundholding GPs.

2.1. Fundholding and after

The high take-up rate of fundholding suggests that any early misgivings did not prevent a large number of GPs from eventually joining the scheme. The first waves of recruitment tended to attract those with entrepreneurial flair, GPs who welcomed the scope for independence and initiative that an independent budget offered [8,9]. However, many subsequent arrivals found practice management more to their liking than they had initially expected [10]. Especially in urban areas, where the density of GPs was higher, individual practices began to collaborate as 'multi-funds', pooling their budgets to obtain economies of scale and scope.

One of the first tangible results of fundholding was the constrained growth in prescribing costs. Faced with a cash-limited purchasing budget, fundholding GPs quickly realised that the cost of their prescribed medication was their most controllable area of spending and took steps to rationalise their prescribing. In the absence of a practice budget, non-fundholders naturally faced no such pressure [11]. As a result, the prescribing cost growth rates of the two groups began to diverge [12]. This consequence, it should be pointed out, had been foreseen by the architects of the 1990 NHS Act, who had identified the control of escalating drug costs in primary care as a principal policy objective [5]. The apparent success of fundholding in constraining prescribing cost growth led to the implementation of local incentive schemes amongst non-fundholders, offering tangible rewards for those successful in moderating their costs [13].

Although a proportion of the later arrivals to fundholding were probably influenced simply by a 'bandwagon effect', many new recruits were undoubtedly attracted by perceptions of fundholder advantage. Fundholders received additional management allowances and any end-of-year surpluses from the fund were available for discretionary use, enabling practices to offer new and additional services. A growing number of hospitals were offering specialist outreach clinics to their fundholder customers, thereby shortening the expected patient waiting times for outpatient appointments [14,15]. Indeed, hospital waiting times generally appeared to be shorter for fundholder patients [16,17]. Fundholders seemed to be capable of purchasing care at lower prices, in comparison to HAs [18]. A creeping suspicion was emerging amongst non-fundholders that fundholding GPs were receiving more care resources per patient than they were, although there was little real evidence to support this view [19]. Even so, it appeared to many that a 'two-tier' NHS was being created; fundholders experienced superior conditions of service and their patients had better access to health care.

The fundholding controversy notwithstanding, GPs in general remained concerned about their terms of service. They had become disaffected with what they saw as the imposition—as opposed to negotiation—of a revised contract, as a prelude to the 1990 Act [20]. In 1996, they debated the possibility of re-defining

their obligations in terms of 'core' and 'non-core' activities, as a response to the view that too much was being expected of them as a matter of routine [21]. One particular concern was the care of elderly patients in nursing homes. GPs had come to believe that the workload and prescribing costs entailed by the responsibility for such patients was disproportionate to the capitation payments received, a belief subsequently validated by empirical research [22–24]. Whilst some HAs appeared willing to negotiate additional payments for GPs taking on nursing home responsibilities, others were less enthusiastic [25].

In 1996, a government White Paper [26] outlined the prospect of a new diversity in primary care organisation. This included the radical option of a salaried GP service, thereby re-visiting an NHS proposal of some 50 years earlier. General NHS funding and rationing continued to preoccupy the profession. Although health care had largely been provided free at the point of access since 1948, the issue of charging for GP services was aired, as a means of constraining the growth in public demand. User charges were debated at the national conference of local GP medical committees in 1997 but were rejected by a majority of three to one [27].

By 1997, the hospitals' rapid transition to trust status and the equally-speedy take-up of GP fundholding, was leading to the expectation that the internal market structure would soon be completed, in the form in which the 1990 Act had originally envisaged. However, the change of government following the general election in May of that year heralded the likelihood of policy re-direction, in view of the incoming Labour Party's ostensible antipathy to the internal market schemes created under the previous Conservative administration. The imminent abandonment of fundholding was immediately signalled on the grounds of the inequity in provision entailed by the 'two-tier' NHS [28].

The new government's policy intentions [29] were formalised some 6 months after the election. The policy changes were less dramatic than many had expected [30] and much of the later primary care legislation of the previous government was to be carried through. Within the internal market, however, certain roles were to be re-defined. In particular, fundholding was formally abandoned in 1999 and, at the same time, the purchasing functions of HAs and fundholders were subsumed within Primary Care Groups (PCGs). The PCGs were envisaged as co-operative and collaborative organisations, serving patients in a locality of, on average, $\approx 100{,}000$ persons. At this size, the PCG was far larger than the typical general practice, but several times smaller than the typical HA. PCGs were subordinate to their respective HAs and comprised the local GPs and community nurses, with representation from other interested parties, such as local government social services. From the year 2000, PCGs were able, if they were so approved, to assume responsibility for a devolved budget, thereby becoming Primary Care Trusts (PCTs). It should be noted that PCG membership is compulsory for primary care professionals and is defined by local geography. In contrast, under fundholding, GPs had been free to opt into or out of the scheme and, if the former, to form consortia with any other practices by mutual agreement.

3. Method

The two surveys were conducted amongst GPs in the NHS Trent region, an area of east-central England serving a population of ≈ 5 million people. Shortly after the 1997 election, a postal questionnaire, entitled *Improving the NHS*, was mailed to the senior partner of each of the general practices in Trent. The questionnaire was designed for unsupervised self-completion, with responses to be returned in postage-paid envelopes. As many of the matters raised in the questionnaire were controversial, we took the view that permitting anonymity in response would increase the probability of sincere answers.

Respondents were invited to provide information on the characteristics of their practices (including the number of registered patients, size of partnership and fundholding status) and their attitudes with respect to 22 statements. Although not presented formally as such in the questionnaire, the 22 statements had been constructed to reflect three broad themes in contemporary general practice policy issues. These were, firstly, fundholding and the internal market, whose futures were, at the time of this first survey, highly uncertain. We included, secondly, statements reflecting on more general NHS rationing and resource allocation principles and, thirdly, statements relating to the prevailing terms of service in general practice. For each statement, GPs were requested to indicate their opinions on a five-point scale, ranging from 'strongly disagree' (coded 1), 'disagree' (2), 'neutral' (3), 'agree' (4) to 'strongly agree' (5). Given that user charges had recently been the subject of public debate, we also sought GPs' views on the merits of imposing charges for five specified GP services. For those believing a charge to be desirable, we requested their opinion on the appropriate level.

The survey was repeated 3 years later, in mid-2000. In constructing the second survey instrument, we endeavoured to maintain a direct correspondence with the first. Practice characteristics were again requested although, by this time, all those who reported that they had been fundholders had been obliged to relinquish that status. We employed, essentially, the same set of attitudinal statements, although these were re-ordered. Ten attitude statements from the first questionnaire instrument could be reproduced directly in the second, as their content was independent of events. Examples included whether waiting lists for treatment represented the fairest means of rationing care, whether too much NHS funding was devoted to management and whether the salaried service option was desirable. Nine statements from the 1997 survey simply required a change in tense to make them applicable to the year 2000. For example, the 1997 statement that fundholding should not be abolished and should remain available to successful fundholders became, in 2000, a statement to the effect that fundholding should not have been abolished under such circumstances. Views on the benefits of 3–5 year purchaser–provider contracts in the 2000 survey were described as potential benefits in the 1997 survey because, although such contracts had been announced, they had yet to be implemented at that time. Finally, three statements required slight emendation, in view of the creation of PCGs between the two survey dates. PCGs were mentioned explicitly in the 2000 survey instrument, but their potential functions had been referred to more generally as 'locality commissioning' in the 1997 instrument.

Fundholding was an issue which polarised both the rival political parties and GPs throughout the 1990s. Despite initial misgivings, increasing numbers of GPs joined the scheme [31], although many remained resolutely opposed [32,33]. Our attitudinal data were analysed to assess whether the opinions of fundholders and non-fundholders (i) differed at a time when fundholding appeared to be on the verge of abolition; or (ii) continued to differ following that abolition. Accordingly, we stratified our survey responses into four groups (fundholding status by year of survey) and employed one-way analysis of variance for each attitudinal statement, to test for differences in mean response between the four groups. Given multiple comparisons were being made, we employed the Bonferroni or Tamhane corrections, as appropriate.

4. Results

A total of 911 records was obtained from the two surveys, 386 and 525 for the 1997 and 2000 surveys, respectively. These represent response rates of 44.8 and 60.9%, respectively. Rates of 40 or 50% are quite typical of those obtained from GP postal surveys generally, where workload pressures and 'questionnaire overload' appear major factors limiting response [34–37]. Table 1 presents practice characteristics for both survey samples and the test statistics (χ^2 and Mann–Whitney) indicate that differences between the two are statistically insignificant. Judged in these terms, therefore, the samples are comparable. As is evident from the corresponding data for England in 1998 (the last full year of fundholding), the Trent samples are also representative of the overall GP population in England [38].

Table 2 presents the analysis of variance results, with statements re-ordered for convenience of exposition. For 13 statements, no significant changes in average opinion over time were detectable amongst either fundholders (FHs) or non-fundholders (NFHs). Indeed, for the first six of these statements, as presented in Table 2, no significant differences between means across all four groups were observable, implying not only consistency over time, but consistency across organisational status. There was particularly strong agreement with respect to the first two statements that represent, respectively, a long-established principle of the NHS and

Table 1
Comparability of samples

	Samples		Test statistic		$P=$	England 1998
	1997	2000				
Proportion of fundholders (%)	51.3	51.0	χ^2	0.01	0.50	53.7
Mean size of partnership (number of GPs)	3.5	3.3	Z	−1.53	0.13	3.1
Patients per GP	1942	2001	Z	−1.32	0.19	1979

Table 2
Survey results: summary of attitudinal data

Statement	Sample	Responses (%)					Mean	S.D.	Median
		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)			
No changes in opinion; no differences between FHs and NFHs									
1	Patients should be treated on the basis of their needs not on their ability to pay.								
	NFH 1997	1.6	1.6	3.2	17.1	76.5	4.7	0.8	5
	NFH 2000	2.4	2.0	4.7	22.1	68.8	4.5	0.9	5
	FH 1997	3.1	2.0	3.6	31.1	60.2	4.4	0.9	5
	FH 2000	3.8	2.3	4.2	24.5	65.3	4.5	1.0	5
2	Patients should be made aware that not all health care needs can be met.								
	NFH 1997	1.6	2.2	4.3	36.0	55.9	4.4	0.8	5
	NFH 2000	0.8	2.7	3.1	32.5	60.8	4.5	0.8	5
	FH 1997	2.6	1.5	3.1	33.2	59.7	4.5	0.8	5
	FH 2000	1.5	1.5	4.5	36.7	55.7	4.4	0.8	5
3	GPs should receive incentive payments to motivate them to improve their prescribing.								
	NFH 1997	11.9	17.3	29.7	24.3	16.8	3.2	1.2	3
	NFH 2000	9.6	12.0	23.9	31.9	22.7	3.5	1.2	4
	FH 1997	10.2	16.3	25.5	34.2	13.8	3.3	1.2	3
	FH 2000	9.1	12.1	27.9	33.6	17.4	3.4	1.2	4
4	GPs should be paid for the provision of 'non-core' services, such as services to nursing home patients.								
	NFH 1997	1.6	3.8	5.4	38.9	50.3	4.3	0.9	5
	NFH 2000	2.0	5.6	5.6	36.1	50.8	4.3	0.9	5
	FH 1997	2.6	1.5	5.1	31.8	59.0	4.4	0.9	5
	FH 2000	1.9	2.7	8.0	42.8	44.7	4.3	0.9	4
5	Improvements to patient care in general practice can only be achieved by improving the training, resources and support that GPs receive.								
	NFH 1997	1.1	8.1	11.3	44.6	34.9	4.0	0.9	4
	NFH 2000	2.0	2.8	7.6	45.4	42.2	4.2	0.9	4
	FH 1997	1.5	5.6	10.8	47.2	34.9	4.1	0.9	4
	FH 2000	1.9	4.9	7.2	43.6	42.4	4.2	0.9	4

Table 2 (*Continued*)

Statement	Sample	Responses (%)					Mean	S.D.	Median
		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)			
6	GPs should be offered the option of a salaried service.								
	NFH 1997	3.8	6.5	29.7	41.6	18.4	3.6	1.0	4
	NFH 2000	5.6	5.2	32.9	38.9	17.5	3.6	1.0	4
	FH 1997	4.1	8.8	30.4	41.2	15.5	3.6	1.0	4
	FH 2000	5.0	6.1	32.1	38.9	17.9	3.6	1.0	4
No changes in opinion; differences between FHs and NFHs maintained									
7	The government was right to abolish the internal market.								
	NFH 1997	2.2	6.0	16.3	17.4	58.2	4.2	1.1	5
	NFH 2000	2.0	5.7	18.8	31.0	42.4	4.1	1.0	4
	FH 1997	17.8	26.4	23.9	9.6	22.3	2.9	1.4	3
	FH 2000	13.0	24.9	28.4	19.9	13.8	3.0	1.2	3
8	GP fundholding led to a 'two-tier' NHS.								
	NFH 1997	1.1	1.6	1.6	25.7	70.1	4.6	0.7	5
	NFH 2000	0.8	3.6	3.6	30.4	61.7	4.5	0.8	5
	FH 1997	11.7	19.3	19.8	31.0	18.3	3.2	1.3	3
	FH 2000	16.3	19.7	21.2	28.4	14.4	3.0	1.3	3
9	The internal market produced real benefits for patients.								
	NFH 1997	24.3	34.7	28.9	9.8	2.3	2.3	1.0	2
	NFH 2000	20.5	30.5	32.6	13.8	2.5	2.5	1.0	2
	FH 1997	5.1	12.3	18.5	36.4	27.7	3.7	1.2	4
	FH 2000	4.3	11.2	21.7	38.8	24.0	3.7	1.1	4
10	If the amount of administrative work that fundholding practices had to perform had been reduced, the fundholding schemes would have been more effective.								
	NFH 1997	15.1	17.3	43.9	13.7	10.1	2.9	1.1	3
	NFH 2000	9.0	19.9	51.7	13.3	6.2	2.9	1.0	3
	FH 1997	4.7	17.1	23.3	39.4	15.5	3.4	1.1	4
	FH 2000	4.9	18.9	30.3	32.6	13.3	3.3	1.1	3

Table 2 (*Continued*)

Statement	Sample	Responses (%)					Mean	S.D.	Median
		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)			
11	Fundholding should not have been abolished and should have remained available to practices that had demonstrated they could operate the scheme successfully.								
	NFH 1997	35.9	35.9	15.3	6.5	6.5	2.1	1.2	2
	NFH 2000	39.6	29.4	15.5	9.0	6.5	2.1	1.2	2
	FH 1997	7.2	9.3	16.0	32.0	35.6	3.8	1.2	4
	FH 2000	6.5	21.0	11.1	35.1	26.3	3.5	1.3	4
12	The GP fundholding scheme made GPs more aware of how much it cost to treat patients.								
	NFH 1997	7.4	9.9	27.2	48.1	7.4	3.4	1.0	4
	NFH 2000	4.2	6.8	25.0	53.4	10.6	3.6	0.9	4
	FH 1997	3.1	1.5	4.6	40.5	50.3	4.3	0.9	5
	FH 2000	0.8	5.7	7.5	42.6	43.4	4.2	0.9	4
13	More NHS money should be spent on patients and less on management.								
	NFH 1997	1.1	0.0	8.0	28.2	62.8	4.5	0.7	5
	NFH 2000	2.4	0.0	13.9	27.0	56.7	4.4	0.8	5
	FH 1997	3.1	0.0	7.7	17.4	40.0	3.9	1.0	4
	FH 2000	3.4	0.0	6.1	20.1	35.2	3.9	1.0	4
Changes in opinion; no differences between FHs and NFHs									
14	Unless real expenditure on the NHS is increased, the government will be unable to achieve significant improvements in services.								
	NFH 1997	2.7	8.5	8.0	37.2	43.6	4.1	1.0	4
	NFH 2000	1.6	3.2	4.3	26.1	64.8	4.5	0.8	5
	FH 1997	2.6	8.2	8.7	40.8	39.8	4.1	1.0	4
	FH 2000	3.4	2.6	2.3	24.9	66.8	4.5	0.9	5
15	Contracts negotiated on a 3–5 year basis, rather than annually, improve the purchasing of NHS services.								
	NFH 1997	7.5	6.1	42.2	35.4	8.8	3.3	1.0	3
	NFH 2000	3.1	2.6	29.1	52.9	12.3	3.7	0.8	4
	FH 1997	3.6	16.6	27.5	34.2	18.1	3.5	1.1	4
	FH 2000	2.3	8.2	26.8	49.4	13.2	3.6	0.9	4

Table 2 (*Continued*)

Statement		Sample	Responses (%)					Mean	S.D.	Median
			Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)			
Changes in opinion; differences between FHs and NFHs maintained										
16	The government was right to replace the system of purchasing by fundholders and health authorities with PCGs.									
			2.2	1.7	16.7	40.0	39.4	4.1	0.9	4
		NFH 2000	9.1	13.6	33.5	33.5	10.3	3.2	1.1	3
		FH 1997	14.9	20.6	27.3	23.7	13.4	3.0	1.3	3
		FH 2000	19.6	25.0	35.8	14.6	5.0	2.6	1.1	3
17	Fundholders proved themselves competent purchasers of health care and should have been allowed to continue purchasing services, even though PCGs have been introduced.									
		NFH 1997	29.9	38.4	21.3	7.9	2.4	2.1	1.0	2
		NFH 2000	32.1	33.8	21.3	10.8	2.1	2.2	1.1	2
		FH 1997	5.2	9.4	16.1	37.5	31.8	3.8	1.1	4
		FH 2000	5.8	20.8	15.1	35.5	22.8	3.5	1.2	4
18	The operation of the fundholding schemes could have been improved if the expertise of successful, 'leading-edge' fundholders had been used to train the less successful.									
		NFH 1997	16.8	23.1	44.8	11.9	3.5	2.6	1.0	3
		NFH 2000	12.6	21.6	42.9	19.0	3.9	2.8	1.0	3
		FH 1997	6.8	14.7	23.6	43.5	11.5	3.4	1.1	4
		FH 2000	3.1	13.4	15.7	45.6	22.2	3.7	1.1	4
Changes in opinion; earlier differences between FHs and NFHs not maintained										
19	Waiting lists are the fairest way to ration health care.									
		NFH 1997	10.6	17.9	18.4	43.6	9.5	3.2	1.2	4
		NFH 2000	22.3	26.4	21.9	24.8	4.5	2.6	1.2	3
		FH 1997	16.8	26.3	22.6	28.4	5.8	2.8	1.2	3
		FH 2000	24.0	35.7	21.3	16.3	2.7	2.4	1.1	2
20	GPs should not have to consider expenditure when prescribing drugs to their patients and prescribing budgets should therefore be abolished.									
		NFH 1997	11.4	40.3	17.0	13.6	17.6	2.9	1.3	2

Table 2 (*Continued*)

Statement	Sample	Responses (%)					Mean	S.D.	Median
		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)			
	NFH 2000	13.8	34.6	16.1	18.1	17.3	2.9	1.3	3
	FH 1997	31.4	42.8	7.7	11.9	6.2	2.2	1.2	2
	FH 2000	15.8	39.2	19.2	14.0	11.7	2.7	1.2	2
21	GPs have a better understanding than local health authorities of their patients' needs and therefore (PCGs) make better purchasers of health care.								
	NFH 2000	2.0	7.4	23.8	43.4	23.4	3.8	1.0	4
	NFH 1997	1.6	7.6	30.4	33.7	26.6	3.8	1.0	4
	FH 1997	2.6	4.1	9.2	40.8	43.4	4.2	0.9	4
	FH 2000	3.1	5.8	22.6	48.2	20.2	3.8	0.9	4
Changes in opinion; earlier similarities between FHs and NFHs not maintained									
22	NHS resources should be re-distributed in a way that addresses the problems of regional inequalities in health.								
	NFH 1997	1.1	3.2	10.6	53.7	31.4	4.1	0.8	4
	NFH 2000	1.6	2.4	9.1	41.5	45.5	4.3	0.8	4
	FH 1997	1.5	6.1	13.8	50.5	28.1	4.0	0.9	4
	FH 2000	2.3	2.3	12.5	55.9	27.0	4.0	0.8	4
Year 2000 only; no differences between FHs and NFHs									
23	The government's new primary care arrangements will produce real benefits to patients.								
	NFH 2000	13.4	21.9	47.4	14.2	3.2	2.7	1.0	3
	FH 2000	15.2	24.6	44.1	13.3	2.7	2.6	1.0	3

the perceived need to make public expectations of NHS capabilities realistic. Statements three through six each pertain to a specific condition of service in general practice, with the suggested payment for non-core services (statement four) attracting particularly strong agreement.

For statements seven through 13, the views of FHs and NFHs did not themselves change over time, but they did differ significantly, one from another, in both 1997 and 2000. Six of these statements related specifically to fundholding. Perhaps not surprisingly, NFHs in 1997 were significantly less favourably disposed towards fundholding than the FHs of that year. They were more fervent advocates of its abolition, less willing to accept that any benefits resulted from the scheme and more inclined to favour patients over management in terms of resource allocation. FHs, on the other hand, were far more supportive of the organisational form, believing that important lessons could have been learned from the experience. These differences in views evidently persisted until 2000.

For the remaining nine statements, opinions had evidently changed during the 3 years between the surveys. Statements 14 and 15 indicate that both FHs and NFHs became increasingly supportive of longer-term contracting and the need to increase NHS resources generally in order to improve quality. Although FHs continued to remain more opposed than NFHs, both types of practice had evidently become less convinced of the prudence of replacing the pre-1997 purchasing structures with locality purchasing (statement 16). The wisdom of retaining fundholding slightly declined amongst FHs (statement 17), although this group had, by 2000, become marginally more convinced that the operation of the scheme would have improved had FHs been able to pass on their experience (statement 18).

Scepticism as to the equity of rationing by waiting evidently increased on the part of NFHs, bring their views into harmony with those of FHs (statement 19). On the other hand, FHs became less approving of the use of prescribing budgets, as had their NFH counterparts in the earlier survey (statement 20). By 2000, it should be recalled, FHs would no longer have been able to benefit directly from effecting economies in their prescribing budgets, as would have been possible prior to the abolition of fundholding. It is likely that a change in wording accounts for the falling level of FH agreement with respect to statement 21—in the 1997 survey, the statement implied that the GPs themselves made the better purchasers of care. By 2000, NFHs had become slightly more accepting than FHs of the need to redress regional inequalities (statement 22).

As might be expected from the results in Table 2, significant correlations between the responses to the statements specific to fundholding were observable from the data. A factor analysis of the 22 statement responses for each of the two questionnaire samples generated, as the first factor in each case, absolute loadings in excess of 0.6 for statements seven through nine, 11, 12 and 16 through 18 (varimax rotation). The proportion of total variation explained by the first factor was 24.2 and 20.8% for the 1997 and 2000 samples, respectively.

The 2000 questionnaire contained one additional statement (23), relating to GPs' perceptions of the likely impact of the current government's primary care policies on patients. As is evident, both FHs and NFHs were, on average, neutral in their

response in contrast to their more polarised attitudes towards the policies of the previous government (statement nine). An association between attitudes to statement nine and those to statement 23 would be expected, as these are essentially the same question applied to the two policy periods under review. Here, FH and NFH response patterns were different. FH responses to these two statements were significantly negatively correlated ($\rho = -0.29$), implying that enthusiasm for the earlier internal market was associated with pessimism regarding the more recent changes in government policy and vice versa. In contrast, NFH responses were positively correlated ($\rho = 0.24$). This might be interpreted as implying that NFHs' approval (or otherwise) was in terms of their perception of the government's general capacity to influence change for the better, as opposed to any specific policy initiatives.

Table 3 presents the samples' opinions on the level of user charges. Although the proportion of GPs opposed to charges for all five services rose significantly between the two surveys, from 38.2 to 44.7% ($\chi^2 = 3.59$, $P = 0.03$), the majority clearly continued to favour a user charge for at least one primary care service. The proportion in favour of charges for all five services was 21.5% in 1997 and 20.3% in 2000. For two of the services—GP visits to patients' homes and GP out-of-hours visits—the mean level of charge rose significantly between the two surveys. Fundholding status did not emerge as a significant discriminator of attitudes towards charges, although average list-size did. The mean list-size for GPs favouring a charge of one or more services was significantly higher compared with those favouring no charges, in both of the survey years. The former had a mean list-size of 2015 and 2092 for 1997 and 2000, respectively, in comparison with the latter's 1824 and 1892 ($t = -3.59$ and -4.22, $P < 0.01$ in both cases). There was no evidence of any statistical association between opinions on charges and the fairness of rationing by waiting (statement 19).

5. Discussion

Three main conclusions may be drawn from the above results. First, and although the abolition of fundholding was signalled only 6 years after its introduction, fundholders became significantly more supportive of it than those remaining outside the scheme. Such a finding in our initial survey is perhaps not surprising, as recruits to fundholding were self-selected, yet our subsequent survey shows that their enthusiasm for the scheme was not dissipated once fundholding had been abolished. Second, professional attitudes other than those towards fundholding and especially those with respect to terms of service, remained homogenous to a considerable degree. Finally, it was the GPs with the longer patient lists who expressed the greater enthusiasm for user charges.

Even at the height of its influence, GPs committed to fundholding remained in a minority and, in the general population of medical professionals, a preponderance of disapproval for the scheme has been reported from surveys [39,40]. Even combining our FH and NFH samples, we find that the majority of our GPs either

Table 3
GP opinions on user charges

	1997			2000			t-Test ($P=$)
	In favour (%)	Of those in favour:		In favour (%)	Of those in favour:		
		Mean (£)	95% CI (£)		Mean (£)	95% CI (£)	
Consultation with GP	42.9	10.9	9.5–12.3	40.4	11.8	10.4–13.2	0.40
Home visit by GP	57.2	20.3	18.1–22.5	51.0	25.0	22.7–27.4	0.01
Out-of-hours visit by GP	61.3	38.5	34.5–42.5	54.3	44.8	40.5–49.2	0.04
Consultation with practice nurse	38.2	7.3	6.5–8.2	34.6	8.7	7.3–10.0	0.13
Issue of a repeat prescription	24.5	4.0	3.4–4.7	21.8	7.2	1.8–12.6	0.31

agreed or strongly agreed that the government had been right to abolish the internal market (statement seven, 53.1 and 52.9% for 1997 and 2000, respectively). The views of the minority, however, are not insubstantial. In our combined samples, 39.4 and 40.4% agreed or strongly agreed that the internal market had produced real benefits to patients (statement nine, 1997 and 2000, respectively). These proportions accord well with those derived from an earlier survey of 323 GPs in six areas of England, wherein 38% believed that the quality of services provided had improved since 1990 [41].

Whether these perceived improvements were real remains a moot point. Evidence as to the success of the great British fundholding experiment is ambiguous, partly owing to the limited period of time during which the experiment occurred and partly owing to the difficulty of identifying measurable outcomes [42–44]. Observable change at the macro level proved difficult to detect and there is little evidence that the fundholding scheme enabled the NHS to economise on resources overall [45]. Whilst some studies [46] reported increases in patient satisfaction following fundholding, others detected no change [47].

At the micro-level, however, the evidence base is stronger. On the basis of the incentive to re-invest budget surpluses into practice development, the range of equipment and primary care services offered within fundholding practices increased relative to those offered by NFHs [9,48]. As noted earlier, FHs faced a clear incentive to rationalise their prescribing and a lower growth in prescribing costs amongst FHs rapidly became observable. An equivalent response has been reported for German GPs faced with strong prescribing budget constraints [49] although, in their case, lax prescribing control meant personal financial liability [50]. With respect to statement 12, there is some evidence [51] to support the opinion that fundholding did indeed make GPs more aware of costs, as the Trent fundholders evidently believed.

Perhaps the crucial point about fundholding, however, is less tangible. For those who embraced the philosophy, fundholding represented a shift in organisational culture and instilled a sense of vision and empowerment [52]. To these converts, fundholding offered the capacity to exercise discretion, a flexibility in response to patient needs and a more appropriate context for operating as the 'small businesses' which, in economic terms, general practices have always attempted to be [53]. We believe that this is reflected in our results, in terms of the persistence of positive fundholder attitudes well beyond the duration of fundholding.

The similarity in FH and NFH opinions relating to general terms of service and user charges suggests that membership of the fundholding scheme had been insufficient to enable FHs to secure any disproportionate advantages in these particular areas. In effect, therefore, fundholding exerted a highly selective impact on that which a practice could achieve. Using their scope for independent action, FHs had indeed experimented with demand management strategies, although few reported substantial successes [54]. Workload pressure has long been recognised as a significant source of job dissatisfaction and stress amongst GPs in the UK [55–59] and GPs with longer list-sizes can expect, other things remaining equal, higher workloads. By 2001, GPs and government were again locked in contract negotia-

tions in which workload pressure was a central issue [60]. Indeed, contemporary concern over terms of service could explain the higher response rate for our second survey.

The observed association between an interest in charging for primary care services and average GP list-size in our survey can reasonably be interpreted as a concern to manage patient demand. Whilst appreciating that charging is a viable option in alleviating workload pressure on GPs, the UK's Royal College of General Practitioners remains opposed to charging in principle, on the grounds of inequity with respect to patients and possible deterrence of seeking care [61]. The fact that a large proportion of our sample holds views directly contrary to those of their professional association strongly suggests that they perceive the need for demand management to be extreme. This having been said, the College, in association with the British Medical Association, has taken the government to task over its most recent health policy statement—the NHS Plan [62]—for ignoring completely the issues of demand management and rationing [63].

It is instructive to compare the English experience with those of two other health care systems. First, the New Zealand health policy followed a similar pattern to that of England during the 1990s [64]. The Nationalist government introduced quasi-market reforms and the devolution of control in 1993. The immediate and very rapid GP response was to collaborate in independent practice associations. These tended to emerge in urban areas, where GP concentration was higher. The associations were very similar in character to English fundholders, being responsible for commissioning services, although their realised savings appear to have been typically greater [65]. GPs within such associations displayed higher levels of workplace satisfaction than GPs in solo or rural practice [66]. Faced with similar circumstances, therefore, many GPs in the two systems came to essentially similar conclusions with respect to a preferred form of organisation.

Second, Israel has, since 1995, initiated its own series of health care reforms. Perhaps the most substantive, from the point of view of GPs, is the possibility of enhancing their 'gatekeeper' role into one familiar in England and in other European systems. Opinions appear polarised. Many policy makers and managers of health insurance funds have opposed the full gatekeeper model, essentially because it would confer considerable power on GPs to influence health care expenditures [67]. GPs themselves appear divided, partly on the basis that they may have been inadequately trained to take such decisions [68] or because they regard the role as radical in relation to their current way of working [69]. A substantial proportion of patients have reported satisfaction with a system of self-referral and express no wish to see gate-keeping introduced [70]. Clearly, these polarities are instantly recognisable in the attitudes of English interest groups over the past decade.

Our intention in this research has been to identify GPs' attitudes towards health care reform in England, although this naturally prompts the question: why should GP attitudes necessarily matter in a government-funded and government-controlled health care delivery system? Over and above job satisfaction within the profession, there are two significant reasons. First, GP attitudes matter because the medical

community represents a well-organised and powerful political force. In 2001, a poll of GPs suggested that the majority would be willing to resign their NHS contracts in the event of unfavourable negotiations with the government [71]. The central position occupied by GPs in the NHS could require such a threat to be taken seriously and there is something of a precedent. As a result of the failure to negotiate a satisfactory contract with the government in the early 1990s, UK dentists began to restrict the number of NHS patients they were willing to treat. Now, only half accept all categories of NHS patient and subscriptions to private dental insurance have necessarily increased [72]. Given the enthusiasm for user charges that our GP surveys have revealed, the dental model for general practice is by no means unthinkable.

Second, and assuming the threat of resignation remains unenacted, GPs' attitudes will impact upon the fortunes of the new PCTs. Although all GPs in England are now supposedly operating within PCTs, opinions on practice management will remain divided. Many GPs, undoubtedly, retain strong affections for the old fundholding scheme. Ironically enough, for a government which initially espoused the re-centralisation of general practice, the new NHS Plan is to be highly devolved in implementation [73]. Emphasis has been placed on the development of local priorities within a broad national framework and each PCT is required to 'incentivise' general practice. Individual PCT boards (which include GP representatives) are required to develop models which they feel best suit their purpose—this might entail targets and rewards at the PCT level or at the level of the individual practices. Owing to the peculiar geography of fundholding [74], some PCTs contain far more ex-fundholders than others. Accordingly, if, as our results suggest, fundholding ideas remain prevalent, it is quite probable that they will re-emerge in the design of local incentive structures, constructed by those in positions of authority who gained their managerial experience whilst fundholding.

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